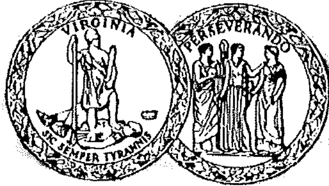
ASSOCIATION EXAMINATION REPORT
of
ANTHEM HEALTH PLANS OF VIRGINIA, INC.
Richmond, Virginia
as of
December 31, 2017

COMMONWEALTH OF VIRGINIA



SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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I, Scott A. White, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Examination Report of Anthem Health Plans of Virginia, Inc. as of December 31, 2017, is a true copy of the original report on file with this Bureau.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed to the original the seal of the Bureau at the City of Richmond, Virginia this 20th day of June 2019

Scott A. White
Commissioner of Insurance

(SEAL)

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Richmond, Virginia
May 9, 2019

Honorable Scott A. White
Commissioner of Insurance
Richmond, Virginia

Dear Sir:

Pursuant to your instructions and by the authority of Section 38.2-1317 of the Code of Virginia, an examination of the financial condition, records and affairs of

ANTHEM HEALTH PLANS OF VIRGINIA, INC.
Richmond, Virginia

hereinafter referred to as the Corporation, has been completed. The report thereon is hereby submitted for your consideration.

SCOPE OF THE EXAMINATION

The last examination of the Corporation was made by representatives of the State Corporation Commission's (the "Commission") Bureau of Insurance (the "Bureau") as of December 31, 2013. This examination covers the four year period from January 1, 2014 through December 31, 2017.

This examination was conducted in accordance with the NAIC Financial Condition Examiners' Handbook (Handbook). The Handbook requires that the Bureau plan and perform the examination to evaluate the Corporation's financial condition, assess corporate governance, identify current and prospective risks of the Corporation and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated both currently and prospectively.

The coordinated examination of the Anthem Group, of which the Corporation is a member, was led by the Indiana Department of Insurance. The examination of the Corporation was conducted concurrently with the examination of the following insurers:

Insurer	Domiciliary State
CareMore Health Plan of Arizona, Inc.	Arizona
Anthem Blue Cross Life and Health Insurance Company	California
HMO Colorado, Inc.	Colorado
Rocky Mountain Hospital and Medical Service, Inc.	Colorado
Anthem Health Plans, Inc.	Connecticut
AMERIGROUP District of Columbia, Inc.	DC
AMGP Georgia Manage Care Company, Inc.	Georgia
Greater Georgia Life Insurance Company, Inc.	Georgia
Blue Cross and Blue Shield of Georgia, Inc.	Georgia
Blue Cross and Blue Shield Healthcare Plan of GA, Inc.	Georgia
AMERIGROUP Iowa, Inc.	Iowa
Anthem Insurance Companies, Inc.	Indiana
UNICARE Life and Health Insurance Company	Indiana
Anthem Life Insurance Company	Indiana
Anthem Health Plans of Kentucky, Inc.	Kentucky
Anthem Kentucky Managed Care Plan, Inc.	Kentucky
AMERIGROUP Louisiana, Inc.	Louisiana
Anthem Health Plans of Maine, Inc.	Maine
AMERIGROUP Maryland, Inc.	Maryland
HealthLink HMO, Inc.	Missouri
Healthy Alliance Life Insurance Company	Missouri
HMO Missouri, Inc.	Missouri
AMERIGROUP Mississippi, Inc.	Mississippi
AMERIGROUP New Jersey, Inc.	New Jersey
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
AMERIGROUP Nevada, Inc.	Nevada
CareMore Health Plan of Nevada	Nevada
Anthem Life and Disability Insurance Company	New York
AMERIGROUP Ohio, Inc.	Ohio
Community Insurance Company	Ohio
AMERIGROUP Oklahoma, Inc.	Oklahoma
AMERIGROUP Insurance Company	Texas
AMERIGROUP Texas, Inc.	Texas
HealthKeepers, Inc.	Virginia
AMERIGROUP Washington, Inc.	Washington
UNICARE Health Plans of WV, Inc.	West Virginia
Blue Cross Blue Shield of Wisconsin	Wisconsin
Compcare Health Services Insurance Corporation	Wisconsin
Wisconsin Collaborative Insurance Company	Wisconsin

All accounts and activities of the Corporation were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. The examination does not attest to the fair presentation of the financial statements included herein.

The examination report includes significant findings of fact and general information about the insurer and its financial condition. There may be other items identified during the examination, that, due to their nature (e.g. subjective conclusions, proprietary information, etc.), are not included within the examination report but separately communicated to other regulators and/or the Corporation.

HISTORY

The Corporation is a stock accident and sickness insurance company licensed under and subject to the general insurance laws contained in Title 38.2 of the Code of Virginia. The Corporation was initially chartered on October 14, 1935 as the Richmond Hospital Service Association and its name was changed to Blue Cross of Virginia in 1968. Blue Shield was chartered on October 21, 1944 as the Associated Doctors of Virginia and its name was changed to Blue Shield of Virginia in 1968. On March 31, 1982, Blue Shield of Virginia was merged into Blue Cross of Virginia. In 1986, Blue Cross and Blue Shield of Southwestern Virginia was merged into Blue Cross and Blue Shield of Virginia.

During 1996, the Corporation submitted a plan of demutualization to the Commission under which it would be converted to a stock insurance corporation, change its name to Trigon Insurance Company and become a wholly-owned subsidiary of a newly formed holding company, Trigon Healthcare, Inc. ("THI"). The Commission approved the plan effective February 1997. The plan included the sale of 17.8 million shares of common stock through an initial public offering and the distribution of 24.4 million shares of common stock to the existing membership. After the conversion, the Corporation and its affiliates underwent a major reorganization with the intent of streamlining the corporate structure. Several subsidiaries were disposed of by dividend and then merged with and into other affiliates.

In April 2002, the Corporation's ultimate parent, THI, announced an agreement in principle to merge with Anthem, Inc. ("Anthem"), an Indiana domiciled insurance holding company specializing in Blue Cross and Blue Shield type organizations. This transaction consisted of an exchange of Anthem stock plus cash for each share of THI stock. Under the agreement and plan of merger, THI merged into a wholly owned subsidiary of Anthem and changed its name to Anthem Southeast, Inc. ("Anthem Southeast"). The acquisition of THI by Anthem was approved by the Commission and was finalized effective July 31, 2002.

On October 27, 2003, Anthem and WellPoint Health Networks, Inc. ("WellPoint Health Networks") announced an agreement and plan of merger in which WellPoint Health Networks and all WellPoint Health Networks' subsidiaries would merge into a wholly owned subsidiary of Anthem. The transaction consisted of an exchange of Anthem stock plus cash for each share of WellPoint Health Network's stock. Pursuant to the merger, WellPoint Health Network merged with and into Anthem Holding Corp., a direct and wholly-owned subsidiary of Anthem, with Anthem Holding Corp. being the surviving entity. The merger was approved by the Commission and the transaction was finalized effective November 30, 2004. In connection with the merger, Anthem amended its articles of incorporation to change its name to WellPoint, Inc. ("WellPoint"). Effective December 2, 2014, WellPoint changed its name to Anthem, Inc. At December 31, 2017, the Corporation is a wholly-owned subsidiary of Anthem Southeast.

MANAGEMENT AND CONTROL

The bylaws of the Corporation provide that the affairs of the Corporation shall be managed by a board of three directors. A majority of the directors shall constitute a quorum for the transaction of business.

The officers of the Corporation shall consist of a Chairman of the Board, a President, a Secretary, a Treasurer, and such other officers as the board may from time to time deem necessary. The Chairman of the Board shall have the authority to appoint administrative officers such as Vice Presidents, Assistant Secretaries and Assistant Treasurers and to perform such functions and duties as prescribed and approved by the President. The President shall be the Chief Executive Officer and shall perform such duties as may be required by law or as may be delegated to him by the Board of Directors. At December 31, 2017, the Board of Directors and Officers of the Corporation were as follows:

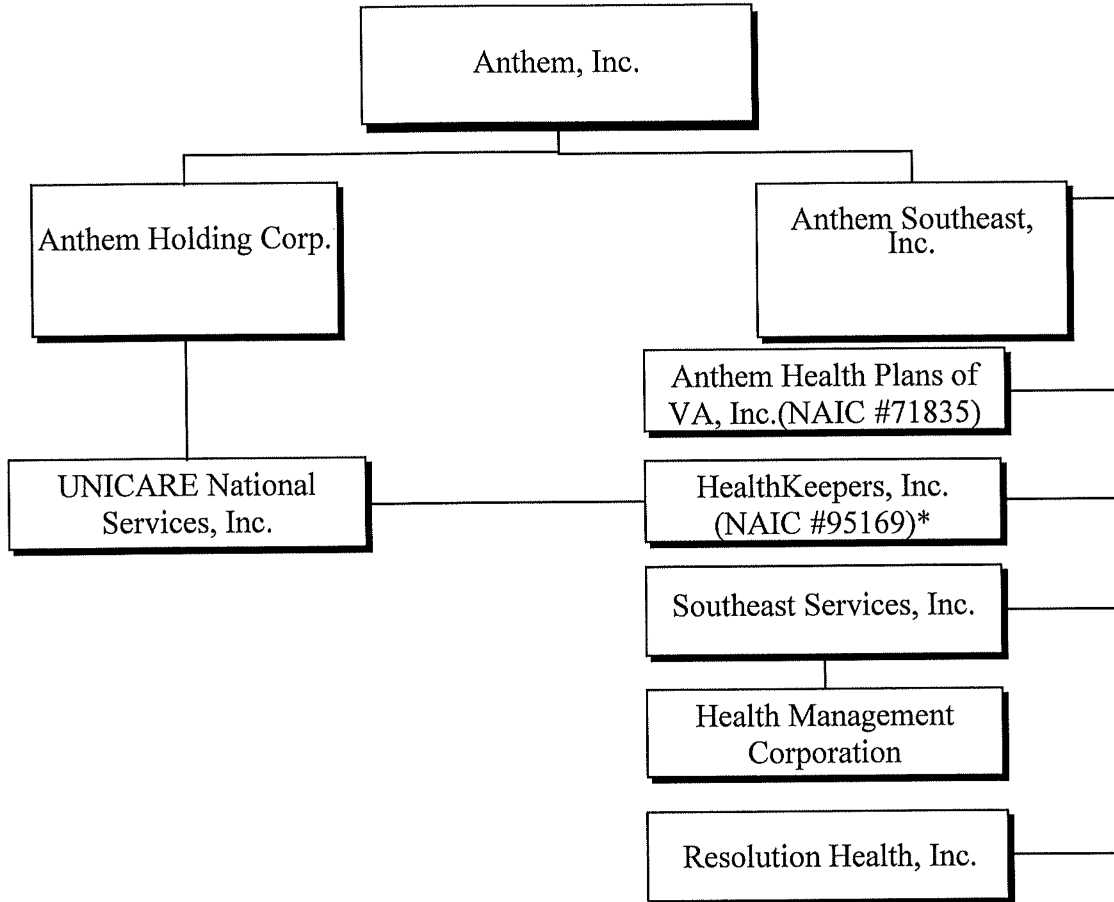
Director	Principal Occupation
Catherine I. Kelaghan	Vice President and Counsel Anthem, Inc. Indianapolis, Indiana
Ronald W. Penczek	Senior Vice President and Chief Accounting Officer Anthem, Inc. Indianapolis, Indiana
George F. Ricketts, Jr.	President Anthem Health Plans Richmond, Virginia

Officers

George F. Ricketts, Jr.	Chairman and President
Kathleen S. Kiefer	Secretary
Sidney O. Hunt	Assistant Secretary
Robert D. Kretschmer	Treasurer
Eric K. Noble	Assistant Treasurer

The Corporation's authorized capital is 200,000 shares of common stock with a par value of $10 per share. At December 31, 2017, there were 100,000 shares issued and outstanding.

The Corporation is a member of an insurance company holding system as defined in Section 38.2-1322 of the Code of Virginia. The chart on the following page illustrates the organizational structure of the Corporation and selected affiliated entities at December 31, 2017.



* HealthKeepers, Inc. is 92.51% owned by Anthem Southeast, Inc. and 7.49% owned by UNICARE National Services, Inc.

TRANSACTIONS WITH AFFILIATES

Cash Concentration Agreement

Effective April 1, 2010, the Corporation entered into a Cash Concentration Agreement with WellPoint and its direct or indirect affiliates whereby WellPoint and certain affiliates are designated Cash Managers to handle the receipt and/or disbursement of funds on behalf of one or more affiliates. When a Cash Manager receives funds on behalf of an affiliate, an intercompany payable to the affiliate is established. When a Cash Manager disburses funds on behalf of an affiliate, an intercompany receivable from the affiliate is established. All resulting intercompany payables and receivables shall be settled within 30 days unless the parties mutually agree to settlement at a later date no later than 90 days after the intercompany payable or receivable was established. The Cash Manager shall be reimbursed monthly for all direct and indirect allocable costs it incurs in its capacity as Cash Manager.

Master Administrative Services Agreement

Effective January 1, 2006, the Corporation entered into a Master Administrative Services Agreement with WellPoint and its subsidiaries and affiliates. According to the agreement, each affiliate that is party to the agreement may provide certain administrative, consulting and support services to another affiliate upon request. The affiliate rendering services shall be reimbursed for the direct and indirect costs and expenses incurred in providing such services and reimbursement is due within 30 days upon receipt of a statement for the services rendered. The term of the agreement is one year and shall be automatically renewed for additional one-year periods unless terminated upon 90 days written notice. The Corporation incurred $411,530,000 in fees related to the agreement in 2017.

Consolidated Federal Income Tax Agreement

Effective December 31, 2005, the Corporation became a party to a Consolidated Federal Income Tax Agreement with WellPoint and selected subsidiaries. The agreement establishes methods for allocating the consolidated federal income tax liability of the consolidated group among its members, for reimbursing WellPoint for payment of such tax liability, for compensating any member for use of its tax losses or tax credits and to provide for the allocation and payment of any refund arising from a carryback of losses or tax credits for subsequent taxable years. For each consolidated federal return year, each member shall pay WellPoint an amount equal to the federal income tax payments it would incur if it were filing a separate federal income tax return. Such payments shall be made to WellPoint no later than 30 days after these payments would be due to the federal government if the subsidiary were filing a separate return. For each consolidated federal

return year, WellPoint shall pay each member an amount equal to the reduction in the federal income tax liability of the consolidated group, if any, resulting from the use in any taxable year of tax benefits attributable to such member, including the use of net operating losses or tax credits. In the event of a refund, WellPoint shall pay each member its proportional share within 30 days after the refund is received.

Excess Medical Stop Loss Agreement

Effective January 1, 2000, the Corporation entered into an Excess Medical Stop Loss Agreement with HealthKeepers, Inc. ("HealthKeepers"). Pursuant to the agreement, the Corporation shall reimburse HealthKeepers 100% of the losses paid during the annual twelve-month policy period ending December 31st in excess of the deductibles specified within the agreement.

For the purposes of this policy, losses are defined as amounts that are paid by HealthKeepers for medical expenses covered under the contract; in settlement of claims for medical expenses covered under the contract; or in satisfaction of judgments for medical expenses covered under the contract. Medical expenses are defined as covered charges for inpatient services rendered by hospitals, rehabilitation and skilled nursing facilities to persons enrolled under contracts and transplant services fees charged by transplant service providers. For hospital, rehabilitation, skilled nursing facility or transplant service expenses, each expense shall be deemed to be incurred upon the date of admission to the hospital, rehabilitation or skilled nursing facility.

This agreement contains a provision that requires HealthKeepers to pay the Corporation up to a maximum of 30% of the initial premium if the paid losses exceed 85% of initial premium. Conversely, the Corporation is required to return to HealthKeepers up to 30% of the initial premium when paid losses are less than 85% of the initial premium.

The maximum lifetime excess insurance indemnity payable under this agreement for any one member shall not exceed $2,000,000. The agreement includes a continuation of coverage clause and a benefits conversion clause in the event of HealthKeepers' insolvency. Premiums and claims assumed by the Corporation related to this agreement during 2017 were $13,529,497 and $8,581,800, respectively.

Solvency Guarantee Agreement

The Corporation guarantees the performance, obligations, and solvency of HealthKeepers through a solvency guarantee agreement entered into effective April 9, 1986. This agreement remains in effect unless and until reasonable prior written notice has been given by either party to the other and the Commissioner of Insurance of the Commonwealth of Virginia has granted prior approval for such termination.

This solvency guarantee agreement was amended September 1, 1987 to include the Corporation's agreement that in the event HealthKeepers shall cease operations for any reason, the Corporation's coverage will be offered to all of HealthKeepers' members without exclusions, limitations, or conditions based on health reasons.

Surplus Notes

The Corporation holds subordinated debt in its affiliate, HealthKeepers, with principal balances of $8,716,141 at December 31, 2017.

Dividends to Stockholders

On October 14, 2014, the Commission approved the Corporation's request to pay an extraordinary dividend of $335,000,000 and the Corporation paid this dividend on October 15, 2014. The Corporation paid ordinary cash dividends of $226,900,000, $216,100,000 and $234,900,000 in 2017, 2016 and 2015, respectively. These dividends were paid to the Corporation's sole shareholder, Anthem Southeast.

TERRITORY AND PLAN OF OPERATION

At December 31, 2017, the Corporation was authorized to transact the business of accident and sickness insurance throughout the Commonwealth of Virginia except for a small area of Northern Virginia.

The Corporation markets its products and services to both individuals and groups. The individual products, which is approximately 12% of total enrollment as of December 31, 2017, are marketed principally through direct marketing initiatives and through brokers. The group market, which is approximately 88% of total enrollment as of December 31, 2017, includes small, medium and large group employers. The Corporation also uses a salaried direct sales staff to market the full range of products and services. Sales offices are in the following cities: Bristol, Lynchburg, Newport News, Reston, Richmond, Roanoke, and Virginia Beach.

The Corporation contracts with various health care providers in the area served. These include, among others, hospitals, physicians, lab services, behavioral health providers and facilities, vision services, nursing homes, home health care facilities, alcohol or drug treatment facilities, pharmacies and dentists. These contractors are designated as participating providers and as such render services to subscribers of health care plans administered by the Corporation in accordance with the agreements. Hospital providers are generally paid based on fixed rate DRGs (Diagnosis Related Groups), per diems (i.e., fixed fee schedules where the daily rate is based on the type of service and is the primary method of in-patient reimbursement), per case per admission (i.e., fixed fee schedules for

all services during a member's hospitalization), or in a few cases, a percentage of covered charges with limits on the subsequent year increases. The average rates negotiated with hospitals under these arrangements are lower than the hospital's average standard retail charges. Services not subject to special per case or per diem payment arrangements are generally paid according to a fee schedule or as a percentage of covered charges. Outpatient hospital payments are based on a fixed fee schedule or 90% of billed services. The outpatient fee schedule uses Ambulatory Procedure Code relative weights. Physician contracts employ fixed fee schedules, which are below standard billing rates. The Corporation uses three basic components to establish the physician fee schedule payments: The Center For Medicare/Medicaid Services' (CMS) Resource Based Relative Value System methodologies, competitor reimbursement rates and ongoing reviews of specific allowances to determine if suitable payment levels are in place. Contracts are adjusted when considered appropriate in accordance with the Ethics and Fairness in Carrier Business Practices Act.

The administration of group contracts and claims is primarily handled at the principal office in Richmond. This responsibility includes rating, underwriting, issuing, billing and collecting for all subscriber agreements and the processing and payment of all claims. The Roanoke office is responsible for individual business and member services for some group accounts. The Federal Employee Program (FEP) is primarily administered from Anthem's office in Mason, Ohio.

The Corporation offers health insurance (at risk) for both individuals and groups and also administers uninsured (not at risk or administrative services only) business for qualifying groups and organizations. The amount of business is approximately split 57% for at risk and 43% for not at risk. Group coverage is the most prevalent.

The Corporation has several basic methods of funding the group health care programs. The various means are briefly described below.

1. Fully-insured funding is limited to groups with 2 or more enrollees. The Corporation retains 100% of the risk. The premium is fixed and guaranteed for a term of 12 months assuming no more than a 10% change in the total enrollment or enrollment distribution by location, product, or membership tier, no change in products, or no change in requested services from those assumed when setting the premiums. For accounting purposes, the groups are pooled; gains and losses are not carried forward nor is a formal accounting prepared. The Corporation holds the claim reserves for incurred but not reported liabilities. An individual excess claim pooling limit is required. There is no financial settlement at termination.

2. Aggregate Stop Loss funding is limited to groups with 100 or more enrollees. The risk is shared by the group and the Corporation. The group is responsible for its claims, reinsurance fees and retentions costs; however, claims are capped at an aggregate stop loss limit. Specific stop loss coverage is required. An annual cash settlement is made and no additional balance or deficit is carried forward. The group holds its own claim reserve. If the agreement is cancelled on the anniversary date, there is no stop loss coverage on the run out claims and the group assumes 100% of the risk for its run out exposure. If the agreement is cancelled at any time other than the anniversary date, the specific and aggregate stop loss coverage is terminated retroactively to the beginning of the policy year. Any qualified group may purchase a cap on the incurred but not reported claims, but the decision to purchase this aggregate stop loss coverage on run out claims must be made prior to the effective date of the policy.

3. Minimum Premium funding is limited to existing groups with 100 or more enrollees. This funding is being phased out; while the Corporation is grandfathering existing groups, the funding is not available to new groups. The risk is shared by the Corporation and the group. Unlike the aggregate stop loss funding that caps claims and capitation, the minimum premium funding caps claims and capitation, as well as, retention charges. All other aspects of the funding are similar to those under the aggregate stop loss funding.

4. ASO (Administrative Services Only) funding is limited to groups with 250 or more enrollees. The group is 100% at risk. There is no stop loss coverage on claims paid during the policy period or during the run out period. The group holds the claim reserves. An individual specific stop loss limit is recommended, but is optional. At termination, cash settlements are made for any deficit that exists plus the run out of claims.

5. Administrative Service Agreement with Limited Risk Aggregate Stop Loss Coverage is limited to groups with 100 or more enrollees. The risk is shared by the group and the Corporation. The group is responsible for its claims, reinsurance fees and retention costs. With Limited Risk Aggregate Stop Loss funding, the Corporation establishes a

fund to cover the terminal liability which is charged monthly to the group. Therefore, should the group terminate, it will not be billed for claims run out. Specific stop loss coverage is required. An annual cash settlement is made and no additional balance or deficit is carried forward. The group holds its own claim reserve. If the agreement is cancelled on the anniversary date, there is no stop loss coverage on the run out claims and the group assumes 100% of the risk for its run out exposure. If the agreement is cancelled at any time other than the anniversary date, the specific and aggregate stop loss coverage is terminated retroactively to the beginning of the policy year. Any qualified group may purchase a cap on the incurred but not reported claims, but the decision to purchase this aggregate stop loss coverage on run out claims must be made prior to the effective date of the policy.

Payment methods for funding other than fully insured fall into three categories:

1. Billed rates with year-end settlement. Interest is credited on surplus balances or charged on deficit balances monthly.
2. Weekly or monthly prepayments with the balance due upon receipt of the accounting statement prepared and sent by the third Monday of the following month. An annual accounting is prepared within 90 days of the end of the policy year.
3. Weekly claim payments with the balance due upon receipt of the accounting statement prepared and sent by the third Monday of the following month. An annual accounting is prepared within 90 days of the end of the policy year.

The underwriting practices with regard to waiting periods, exclusions and eligibility for individual or group coverage are defined in each type of contract offered. Only administrative fees from not at risk business are to be reflected in the Corporation's annual operating results.

AFFILIATIONS WITH OTHER PLANS

As a controlled health affiliate of Anthem, Inc., the Corporation participates in the Blue Cross and Blue Shield Association ("Association"), a non-profit Illinois corporation, which is the national coordinating agency for member plans. The purpose of the Association is to serve as the cohesive force that brings the Blue Cross and Blue Shield Plans ("Plans") together into a national system. The Association's role was defined more than 40 years ago when the Plans formed their separate, national coordinating bodies. The Association is governed by representatives of the Member Plans. The Board of Directors of the Association is the principal governing body. The Board of Directors consists of all Plan chief executive officers who wish to serve on the Board and the president of the Blue Cross and Blue Shield Association.

The Corporation, if legally able, assumes certain obligations, including participation in the following national agreements:

BlueCard Program

As an Association licensee, the Company participates in the BlueCard program. BlueCard is a nationwide program that enables members who need health care services while traveling or living in another Plan's service area to access their benefits through the local Plan's providers. It also allows the cost of the services to be calculated in accordance with the local Plan's contract with the providers.

National Accounts Agreement

National accounts are groups of subscribers located in different areas serviced by more than one participating plan. The national account groups are enrolled through a participating plan called a control plan. The control plan is usually the plan servicing the geographical area of the group's headquarters. National accounts' benefits are paid based on the local plans' medical policy.

Federal Employee Program

Under a plan participation agreement with the Association, the Corporation provides health care benefits as described by the Government-wide Service Benefit Plan to those employees, annuitants and their dependents in Virginia who are enrolled under the contract between the Association and the United States Office of Personnel Management.

GROWTH OF THE CORPORATION

The following data represents the growth of the Corporation for the ten-year period ending December 31, 2017. The data is compiled from the Corporation's filed Annual Statements, previous examination reports and the current examination report.

	Admitted Assets	Liabilities	Capital Paid-Up	Paid-In & Unassigned Surplus	Premium Income	Net Income
2008	$1,627,260,654	$1,085,840,955	$1,000,000	$540,419,699	$3,848,435,660	$321,357,975
2009	1,608,486,941	982,748,241	1,000,000	624,738,700	3,774,149,238	333,982,527
2010	1,872,584,841	1,195,197,556	1,000,000	676,387,285	3,829,772,062	393,216,049
2011	1,830,525,050	1,295,949,438	1,000,000	533,575,612	4,010,291,814	250,651,841
2012	1,986,897,662	1,262,940,094	1,000,000	722,957,568	4,149,674,296	345,138,781
2013	1,969,969,942	1,326,774,970	1,000,000	642,194,972	4,006,686,029	269,511,983
2014	1,962,549,905	1,339,446,310	1,000,000	622,103,595	3,938,235,234	242,472,979
2015	1,991,948,150	1,397,718,094	1,000,000	593,230,056	3,726,282,295	216,147,404
2016	1,941,231,175	1,285,966,933	1,000,000	654,264,242	3,925,962,802	230,161,116
2017	2,271,802,319	1,573,633,635	1,000,000	697,168,684	3,685,534,891	241,008,242

FINANCIAL STATEMENTS

The following financial statements present the financial condition of the Corporation for the period ending December 31, 2017. No examination adjustments were made to the statutory financial statements filed by the Corporation with the Bureau for the period ending December 31, 2017.

ASSETS

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$680,725,269		$680,725,269
Common stocks	252,490,069		252,490,069
Properties occupied by the company	27,146,794		27,146,794
Cash, cash equivalents and short-term investments	(23,037,366)		(23,037,366)
Other invested assets	228,740,457	290,392	228,450,065
Receivable for securities	331,431		331,431
Securities lending reinvested collateral assets	35,131,924		35,131,924
Subtotals, cash and invested assets	$1,201,528,578	$290,392	$1,201,238,186
Investment income due and accrued	6,818,261		6,818,261
Uncollected premiums and agents' balances in the course of collection	67,535,458	3,827,259	63,708,199
Deferred premiums, agents' balances and installments booked but deferred and not yet due	176,757,767		176,757,767
Accrued retrospective premiums and contracts subject to redetermination	29,147,491		29,147,491
Amounts receivable relating to uninsured plans	222,983,601	5,761,107	217,222,494
Net deferred tax asset	33,341,819		33,341,819
Guaranty funds receivable or on deposit	49,924,946		49,924,946
Electronic data processing equipment and software	1,552,948	716,833	836,115
Furniture and equipment	11,337,021	11,337,021	0
Health care and other amounts receivable	20,209,172	11,792,406	8,416,766
Aggregate write-ins for other than invested assets	485,532,037	1,141,762	484,390,275
Total assets	$2,306,669,099	$34,866,780	$2,271,802,319

LIABILITIES, CAPITAL AND SURPLUS

	Total
Claims unpaid	$314,174,868
Accrued medical incentive pool and bonus amounts	4,512,557
Unpaid claim adjustment expenses	9,790,965
Aggregate health policy reserves	56,854,122
Aggregate health claim reserves	503,799
Premiums received in advance	54,362,380
General expenses due or accrued	75,874,241
Current federal income tax payable	5,392,863
Ceded insurance premiums payable	3,377,308
Amounts withheld or retained for the account of others	47,023,119
Remittances and items not allocated	29,830,630
Borrowed money	130,015,329
Amounts due to parent, subsidiaries and affiliates	276,879,063
Derivatives	49,000
Payable for securities	2,516,111
Payable for securities lending	35,131,924
Liability for amounts held under uninsured plans	146,582,840
Aggregate write-ins for other liabilities	380,762,516
Total liabilities	$1,573,633,635
Aggregate write ins for special surplus funds	$68,955,018
Common capital stock	1,000,000
Gross paid in and contributed surplus	258,498,945
Unassigned funds (surplus)	369,714,721
Total capital and surplus	$698,168,684
Total liabilities, capital and surplus	$2,271,802,319

STATEMENT OF REVENUE AND EXPENSES

Net premium income	$3,658,534,891
Change in unearned premium reserves and reserve for rate credits	(483,061)
Total revenues	$3,658,051,830
Hospital/medical benefits	$1,587,615,319
Emergency room and out-of-area	114,938,251
Prescription drugs	708,269,160
Aggregate write-ins for other hospital and medical	623,654,921
Incentive pool, withhold adjustments and bonus amounts	8,288,497
Subtotal	$3,042,766,148
Less:	
Net reinsurance recoveries	(8,581,800)
Total hospital and medical	$3,051,347,948
Claims adjustment expenses	67,122,662
General administrative expenses	227,750,154
Increase in reserves for life and accident and health contracts	(6,145,338)
Total underwriting deductions	$3,340,075,426
Net underwriting gain	$317,976,404
Net investment income earned	$29,099,699
Net realized capital gains	18,829,603
Net investment gains	$47,929,302
Net loss from agents' or premium balances charged off	($5,371)
Aggregate write ins for other income or expenses	2,235,492
Net income before federal income taxes	$368,135,827
Federal income taxes incurred	127,127,585
Net income	$241,008,242

RECONCILIATION OF CAPITAL AND SURPLUS

	2014	2015	2016	2017
Capital and surplus prior reporting year	$643,194,972	$623,103,595	$594,230,056	$655,264,242
GAINS AND LOSSES TO CAPITAL AND SURPLUS				
Net income	$242,472,979	$216,147,404	$230,161,116	$241,008,242
Change in net unrealized capital gains and (losses)	13,895,524	(15,310,821)	31,241,138	23,186,924
Change in net deferred income tax	(34,432,794)	2,678,841	12,715,256	(35,635,838)
Change in nonadmitted assets	92,972,914	893,444	3,154,343	41,382,781
Dividends to stockholders	(335,000,000)	(234,900,000)	(216,100,000)	(226,900,000)
Aggregate write ins for losses in surplus		1,617,593	(137,667)	(137,667)
Net change in capital and surplus	($20,091,377)	($28,873,539)	$61,034,186	$42,904,442
Capital and surplus end of reporting year	$623,103,595	$594,230,056	$655,264,242	$698,168,684

CASH FLOW

Cash from Operations

Premiums collected net of reinsurance	$3,655,499,083
Net investment income	35,251,184
Total	$3,690,750,267
Benefit and loss related payments	$3,087,752,159
Commissions, expenses paid and aggregate write-ins for deductions	378,027,175
Federal income taxes paid	144,834,742
Total	$3,610,614,076
Net cash from operations	$80,136,191

Cash from Investments

Proceeds from investments sold, matured or repaid:	
Bonds	$96,262,543
Stocks	147,737,312
Other invested assets	26,952,017
Net gains on cash and short-term investments	(2,685)
Miscellaneous proceeds	45,216,086
Total investment proceeds	$316,165,273
Cost of investments acquired (long-term only):	
Bonds	$202,321,140
Stocks	55,966,280
Real Estate	1,421,684
Other invested assets	63,813,399
Miscellaneous applications	1,001,386
Total investments acquired	$324,523,889
Net cash from investments	($8,358,616)

Cash from Financing and Miscellaneous Sources

Cash provided (applied):	
Borrowed funds	$40,012,229
Dividends to stockholders	(226,900,000)
Other cash provided	103,431,497
Net cash from financing and miscellaneous sources	($83,456,274)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS

Net change in cash, cash equivalents and short-term investments	($11,678,699)
Cash, cash equivalents and short-term investments:	
Beginning of the year	(11,358,667)
End of the year	($23,037,366)

RECOMMENDATION FOR CORRECTIVE ACTION

Management and Control

1. During the examination, the Examiners requested copies of the amendments to the Excess Medical Stop Loss Agreement that the Corporation originally executed with HealthKeepers, Inc. effective January 1, 2000. These amendments document the rates being charged for the coverage during the specified period covered by the amendment. The Corporation was unable to provide executed copies of these amendments. The Corporation should immediately execute amendments to document the rates covered during the examination period. Additionally, the Corporation should execute amendments any time there is a change in the rates and file these amendments with the Commission, as necessary.

SUBSEQUENT EVENTS

1. Effective January 1, 2018, the Corporation entered into a quota share reinsurance agreement to cede 20% of its direct Federal Employee Program ("FEP") liabilities, net of applicable assets, and 20% of its respective direct FEP written premiums less claims, less a ceding commission to Anthem Insurance Companies, Inc., an affiliated company and authorized reinsurer. This agreement was approved by the Bureau on January 22, 2018.

2. On August 16, 2018, the Corporation declared an extraordinary cash dividend of $300,000,000. The Bureau approved this dividend on September 24, 2018. The Corporation paid the dividend to its parent, Anthem Southeast, on September 25, 2018.

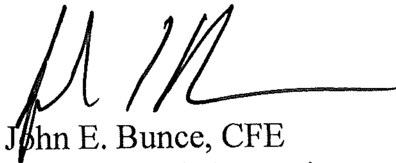
3. On October 17, 2018, the Bureau approved the repayment of HealthKeepers, Inc.'s surplus note, with a balance of $8,716,141 and its related accrued interest of $11,818,406, to the Corporation. The Corporation received these funds on December 2, 2018.

ACKNOWLEDGEMENT

The courteous cooperation extended by the officers and employees of the Corporation during the course of the examination is gratefully acknowledged.

In addition to the undersigned, other individuals from the financial examination staff of the Bureau participated in the work of the examination.

Respectfully submitted,



John E. Bunce, CFE
Assistant Chief Examiner
Commonwealth of Virginia

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Richmond, Virginia 23230

June 18, 2019

David H. Smith
Chief Examiner
Virginia Bureau of Insurance
1300 E. Main Street
Richmond, Virginia 23219

Subject: Examination Report as of December 31, 2017 of Anthem Health Plans of Virginia, Inc.

Dear Mr. Smith:

This letter is the Company's formal response to recommendations for corrective action included in the 2017 examination report for Anthem Health Plans of Virginia, Inc. (The "Company")

1. During the examination, the Examiners requested copies of the amendments to the Excess Medical Stop Loss Agreement that the Corporation originally executed with Anthem Health Plans of Virginia, Inc. effective January 1, 2000. These amendments document the rates being charged for the coverage during the specified period covered by the amendment. The Corporation was unable to provide executed copies of these amendments. The Corporation should immediately execute amendments to document the rates covered during the examination period. Additionally, the Corporation should execute amendments any time there is a change in the rates and file these amendments with the Commission, as necessary.

   Company response: The Company will execute the reinsurance rate amendments agreements covered under the examination period and will file all new rate amendments with the Commission, as necessary.

Sincerely,

Bette Gronseth

Bette Gronseth
Director II Regulatory Reporting, External Financial Reporting
Anthem, Inc.